IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C.L. "BUTCH" OTTER – Governor
RICHARD ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

October 24, 2008

PLEASE NOTE CORRECTED RETURN DATES

Rod Jacobson
Bear Lake Dialysis Center
164 South 5th Street
Montpelier, Idaho 83254

RE: Bear Lake Dialysis Center, provider #132304

Dear Mr. Jacobson:

Based on the survey completed at Bear Lake Dialysis Center on October 10, 2008 by our staff, we have determined that Bear Lake Dialysis Center is out of compliance with the Medicare ESRD Conditions of Participation on Long-Term Program & Care Plan (42 CFR 405.2137), Medical Records (42 CFR 405.2139) and Minimal Service Requirements (42 CFR 405.2163). To participate as a provider of services in the Medicare Program, a ESRD must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Bear Lake Dialysis Center to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **November 24, 2008. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than November 12, 2008.**

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/mlw
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132304	A. BUILDING _____ B. WING _____	10/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR LAKE DIALYSIS CENTER	164 SOUTH 5TH STREET MONTPELIER, ID 83254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your ESRD facility. The surveyors conducting the recertification visit were: Gary Guiles, RN, HFS, Team Leader Patricia O'Hara, RN, HFS Acronyms used in this report include: ADL = Activity of Daily Living AMA = Against Medical Advice Ca = Calcium ESRD = End Stage Renal Disease IDT = Interdisciplinary Team K+ = Potassium MD = Doctor of Medicine POC = Plan of Care PT = Patient PTH = Parathyroid Hormone RN = Registered Nurse SNF = Skilled Nursing Facility SQ = Subcutaneously (under the skin) TX = Treatment WT = Weight	V 000		
V 185	405.2137 LONG-TERM PROGRAM & CARE PLAN Each facility maintains for each patient a written long-term program and a written patient care plan to ensure that each patient receives the appropriate modality of care and the appropriate care within that modality. The patient, or where appropriate, parent or legal guardian is involved with the health team in the planning of care.	V 185		

RECEIVED
NOV 12 2008
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

MP | 11/11/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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V 185	Continued From page 1 This CONDITION is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure written Long Term Programs and written POCs had been developed and updated and that patients were involved with the health team in the planning of care. The cumulative effect of these systemic failures resulted in the inability of the facility to direct staff in the care of patients. The findings include: 1. Refer to V188 as it relates to the facility's failure to ensure Long Term Programs were developed by a professional team, including the physician, transplant surgeon, a qualified nurse, a qualified dietitian, and a qualified social worker. 2. Refer to V189 as it relates to the facility's failure to ensure Long Term Programs were updated at least every 12 months. 3. Refer to V192 as it relates to the facility's failure to ensure there was a written POC for each patient which was based upon the nature of the treatment prescribed and a current assessment of the patients' needs. 4. Refer to V193 as it relates to the facility's failure to ensure there were written POCs for patients that were personalized and included the psychological, social, and functional needs of the patients. 5. Refer to V195 as it relates to the facility's failure to include the patient in the development of the POC.	V 185	Patients will be involved in the Care Plan process. Short Term Care Plan form has been updated to include a discussion with each patient regarding their treatment modality and a place for the patient to sign and acknowledge their participation in the process. (See attachment 1) Part 1: An agreement has been made with the University of Utah Transplant Center to allow Dr. Thakur to determine based on their criteria a patient's transplant status and sign in lieu of a transplant surgeon. All patients deemed eligible for a transplant will be referred to the University of Utah Transplant Center and appropriate treatment options will be given at that time. (See attachment 2) Part 2: A chart audit form has been implemented to ensure that all patients have an updated Long Term Care Plan form at least annually or monthly if the patient is deemed unstable by the interdisciplinary team. (See attachment 3) Part 3: Each patient will be care planned at least quarterly or monthly if the patient is deemed unstable. (See attachment 1) A chart audit is currently being used to ensure each chart is in compliance on a monthly to month basis. (See attachment 3) Part 4: Care plans have been changed to allow for greater flexibility in determining each patient's individual needs. This includes psychosocial needs as well as functional needs. (See attachment 1) Part 5: Patients now give input as to their plan of care and sign that they agree with current treatment plan. (See attachment 1)	11/3/08 11/4/08 11/3/08 11/3/08 11/3/08
V 188	405.2137(a)(1) LONG-TERM PLAN TEAM MEMBERS	V 188		

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V 188	Continued From page 2 There is a written long-term program representing the selection of a suitable treatment modality (i.e., dialysis or transplantation) and dialysis setting (i.e., home, self-care) for each patient that is developed by a professional team which includes but is not limited to the physician director of the dialysis facility or center where the patient is currently being treated, a physician director of a center or facility which offers self-care dialysis training (if not available at the location where the patient is being treated), a transplant surgeon, a qualified nurse responsible for nursing services, a qualified dietitian and a qualified social worker. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure 7 of 9 patients, (#s 2 and 4 - 9) whose Long Term Care Programs were reviewed, had Long Term Programs that were developed by a professional team, including the physician, transplant surgeon, a qualified dietitian and a qualified social worker. This resulted in the inability of the facility to ensure all factors related to the patients' modes of treatment had been explored. The findings include: 1. The Long Term Care Programs for Patients #2 and 4 - 9 were reviewed. The records did not document the Programs were reviewed by the entire professional team as follows: a. Patient #2 was a 54 year old male with diagnoses of chronic kidney disease, diabetes, and a history of drug abuse. He was admitted to the facility on 6/30/06 and was currently a patient as of 9/23/08. A Long Term Program, indicating treatment modality, was dated 12/29/06. It was	V 188	Using our chart audit form, we have ensured that all patients have a Long Term Care Plan signed by each member of the interdisciplinary team. (See attachment 4) An agreement has been made with the University of Utah Transplant Center to allow Dr. Thakur to sign in lieu of the Transplant Surgeon. (See attachment 2)	11/4/08

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V 188	Continued From page 3 not signed by a transplant surgeon, documenting the surgeon's involvement in the development of the Program. b. Patient #4 was an 89 year old male with diagnoses of glomerulonephritis and cardiac problems. He was admitted to the facility on 12/13/06 and was currently a patient as of 9/23/08. A Long Term Program, indicating treatment modality, was dated 12/29/06. It was not signed by the social worker or the transplant surgeon, documenting their involvement in the development of the Program. c. Patient #5 was an 86 year old male with diagnoses of end stage renal disease and long term cardiac disease. He began dialysis at the facility on 6/28/06. His last dialysis treatment occurred on 8/20/08 and he died the following week. A Long Term Program, indicating treatment modality, was dated 12/20/06. It was not signed by the dietician or the transplant surgeon, documenting their involvement in the development of the Program. d. Patient #6 was a 61 year old female with diagnoses of renal failure, diabetes and depression. She began dialyzing at the facility on 5/30/06 and was currently a patient as of 9/23/08. A Long Term Program, indicating treatment modality, was dated 12/20/06. It was not signed by a transplant surgeon, documenting the surgeon's involvement in the development of the Program. e. Patient #7 was a 74 year old male with diagnoses that included ESRD, prostatic cancer and Multiple Myeloma. He was admitted to the facility on 8/20/08. A Long Term Program,	V 188	See page 3 of 74	

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V 188	Continued From page 4 indicating treatment modality, was dated 8/20/08. It was not signed by a physician, a dietician or a transplant surgeon, documenting their involvement in the development of the Program. f. Patient #8 was an 89 year old female with diagnoses of renal failure and diabetes. She was admitted to the facility on 6/5/06. A Long Term Program, indicating treatment modality, was dated 6/5/06. It did not contain the signatures of a social worker or a transplant surgeon, documenting their involvement in the development of the Program. g. Patient #9 was a 60 year old female with diagnoses of renal failure, diabetes and stroke. She was admitted to the facility on 3/28/08. A Long Term Program, indicating treatment modality, was dated 4/4/08. It did not contain the signatures of a physician, a social worker, a dietician or a transplant surgeon, documenting their involvement in the development of the Program. The Nurse Manager was interviewed on 9/25/08 at 1:00 PM. She confirmed that the required signatures were not present. She further stated a transplant surgeon had not been involved in the development of the Long Term Programs. The facility failed to ensure Long Term Programs were developed by a professional team including the physician, transplant surgeon, a qualified dietician and a qualified social worker.	V 188	See page 3 of 74	
V 189	405.2137(a)(2) LONG-TERM PLAN: REVIEWED BY TEAM The program is formally reviewed and revised in writing as necessary by a team which includes but	V 189		

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V 189	Continued From page 5 is not limited to the physician director of the dialysis facility or center where the patient is presently being treated, in addition to the other personnel listed in paragraph (a)(1) of this section at least every 12 months or more often as indicated by the patient ' s response to treatment (see §405.2161(b)(1) and §405.2170(a). This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure the Long Term Program was updated at least every 12 months for 5 of 5 patients (#2, 4 - 6, and 8) who had dialyzed at the facility for at least 18 months. This resulted in the inability of the facility to ensure patients' modes of treatment were evaluated as their needs changed. The findings include: 1. The Long Term Care Programs for Patients #2, 4 - 6, and 8 were reviewed. The records did not document that their Long Term Care Programs were updated at least every 12 months as follows: a. Patient #2 was a 54 year old male with diagnoses of chronic kidney disease, diabetes, and a history of drug abuse. He was admitted to the facility on 6/30/06 and was currently a patient as of 9/23/08. A Long Term Program, indicating treatment modality, was dated 12/29/06. No subsequent, updated Long Term Programs were present in the patient's medical record. b. Patient #4 was an 89 year old male with diagnoses of glomerulonephritis and cardiac problems. He was admitted to the facility on	V 189	Using our chart audit form, we have ensured that all patients have a Long Term Care Plan signed by each member of the interdisciplinary team at least annually. (See attachment 4) An agreement has been made with the University of Utah Transplant Center to allow Dr. Thakur to sign in lieu of the Transplant Surgeon. (See attachment 2)	11/4/08

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V 189	Continued From page 6 12/13/06 and was currently a patient as of 9/23/08. A Long Term Program, indicating treatment modality, was dated 12/29/06. No subsequent, updated Long Term Programs were present in the patient's medical record. c. Patient #5 was an 86 year old male with diagnoses of end stage renal disease and long term cardiac disease. He began dialysis at the facility on 6/28/06. His last dialysis treatment occurred on 8/20/08 and he died the following week. A Long Term Program, indicating treatment modality, was dated 12/20/06. No subsequent, updated Long Term Programs were present in the patient's medical record. d. Patient #6 was a 61 year old female with diagnoses of renal failure, diabetes and depression. She began dialyzing at the facility on 5/30/06 and was currently a patient as of 9/23/08. A Long Term Program, indicating treatment modality, was dated 12/20/06. No subsequent, updated Long Term Programs were present in the patient's medical record. e. Patient #8 was an 89 year old female with diagnoses of renal failure and diabetes. She was admitted to the facility on 6/5/06. One Long Term Program was present in her medical record, dated 6/5/06. No subsequent, updated Long Term Programs were present in the patient's medical record. The Nurse Manager was interviewed on 9/25/08 at 1:00 PM. She confirmed that no updated Long Term Programs were found in the patients' records. Additionally, the facility Administrator was interviewed on 9/25/08 at 4:00 PM. He stated the Long Term Care Programs had not	V 189	See page 6 of 74	

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V 189	Continued From page 7 been updated since they were developed. The facility failed to ensure the treatment modality and setting for all patients was reviewed and updated, by a professional team, at least every twelve months or as indicated by changing patient needs.	V 189	See page 6 of 74	
V 192	405.2137(b) PATIENT CARE PLAN: WRITTEN, ASSESSMENT BASED There is a written patient care plan for each patient of an ESRD facility (including home dialysis patients under the supervision of the ESRD facility; see §405.2163(e)), based upon the nature of the patient's illness, the treatment prescribed, and an assessment of the patient's needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure there was a written POC for each patient which was based upon the nature the treatment prescribed and an assessment of the patients' needs for 8 of 9 patients (#s 2 and 4 - 10), whose POCs were reviewed. This resulted in POCs which were not consistent with physician orders and current assessments of patients' needs. Findings include: 1. The POCs for Patients #7, 9, and 10 were reviewed. The plans were not consistent with the prescribed physician's treatment orders as follows: a. Patient #7 was a 74 year old male with diagnoses that included ESRD, prostate cancer and Multiple Myeloma. He was admitted to the	V 192	In order to ensure that each patient's plan of care is consistent with the written orders for each patient, Dr. Thakur now reviews and signs each patient's Kardex form monthly following patient care plan meeting. (See attachment 5) This form will serve as initial orders for each month. Any changes to these orders will be documented in the Physician's Orders section of each patients chart. During the audit process all patient Kardex are also being checked against physician orders.	11/6/08

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V 192	Continued From page 8 facility on 8/20/08. His record included MD orders, dated 8/20/08, which called for a dialyzer size F160. The Kardex, which was used for set up of daily treatments, the POC called for using a F200 size dialyzer. There was no MD order found for the change in dialyzer size. Additionally, an MD order, dated 8/20/08, called for use of a 2K/2.5Ca dialysate bath. However, the Kardex, reflecting the POC, showed a 3K/2.5Ca dialysate bath was being used. There was no MD order found for a change in the dialysate bath. Initial MD prescription orders, dated 8/20/08, had no numerical value for dialysate flow rate. The Kardex, used for daily treatment parameters, called for a dialysate flow rate of 800ml/minute. There was no subsequent MD order found to indicate the dialysate flow rate parameter. The POC did not reflect the prescribed dialysis prescription. b. Patient #9 was a 60 year old female with diagnoses of renal failure, diabetes and stroke. She was admitted to the facility on 4/4/2008. MD orders, dated 4/4/08, stated a treatment time of 3.75 hours three times a week. On 5/3/2008, an MD order documented a "one time only" change in treatment time to 3 hours. Review of treatment sheets showed the patient's treatment time had remained at 3 hours since the 5/3/08 MD order. The Kardex, used for daily treatments, indicated a dialyzer size of F160. An MD order, dated 7/15/08, called for a change in dialyzer size to an F200. Also, an MD order, dated 4/4/08, called for a dialysate bath strength of 3K/2.5Ca. An MD order, dated 8/11/08, stated that a 1K/ 2.5Ca dialysate bath be used for treatment "one time only." The Kardex and daily treatment sheets showed that a 1K/ 2.5Ca dialysate bath was	V 192	See Page 8 of 74	

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V 192	Continued From page 9 continued until 9/24/08. There was no subsequent MD order, after 8/11/08, indicating the continued use of the 1K/2.5Ca dialysate bath. The POC did not reflect the prescribed dialysis prescription. c. Patient #10 was a 73 year old male with diagnoses of renal failure, diabetes, hypertension and congestive heart failure. He was admitted to the facility on 6/2/08. MD orders, dated 6/2/08, indicated a dialysate flow rate of 600ml/minute. The Kardex, updated on 9/19/08 and used for daily treatment parameters, indicated dialysate flow rate of 800ml/minute. No MD order, indicating a change in the dialysate flow rate, was documented. The POC did not reflect the prescribed dialysis prescription. MD orders, dated 6/2/08, did not specify a dialysate bath strength. A treatment sheet, dated 6/2/08, indicated a 3K/2.5Ca dialysate bath was used for the patient's treatment. The Interdisciplinary Patient Care Plan, dated 7/7/08, noted the patient was being treated with a 1K/2.5Ca dialysate bath. The Interdisciplinary Patient Care Plan, dated 9/3/08, stated the patient was being treated with a 2K/2.5Ca dialysate bath. Individual run sheets, dated 9/10 through 9/24/08, indicated the patient was being treated with a 1K/2.5Ca dialysate bath. There were no MD orders documented during the time period 6/2/08 until 9/24/08 ordering a dialysate bath strength or a change in the dialysate bath strength. The POC did not reflect the prescribed dialysis prescription. The Nurse Manager was interviewed on 9/25/08 at 2:00 PM. She reviewed the above medical records and confirmed that care plans were not	V 192	See Page 8 of 74	

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V 192	Continued From page 10 written according to MD prescriptions. The facility failed to ensure that individual patient care plans were written accurately, based on the treatment prescribed by the physician. 2. Refer to V193 as it relates to the facility's failure to ensure patients' POCs were personalized and included comprehensive psychological, social, and functional information for Patient #'s 2 and 4 - 10.	V 192	See Page 8 of 74	
V 193	405.2137(b)(1) PATIENT CARE PLAN: INDIVIDUALIZED The patient care plan is personalized for the individual, reflects the psychological, social, and functional needs of the patient, and indicates the ESRD and other care required as well as the individualized modifications in approach necessary to achieve the long-term and short term goals. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure there was a written POC for 8 of 9 patients (#2 and 4 - 10), whose POCs were reviewed. The facility failed to ensure POCs were personalized and included psychological, social, and functional needs of the patients. The findings include: 1. The POCs for Patients #2 and 4 - 10 were reviewed. The plans were not personalized and did not include psychological, social, and functional needs of the patients as follows: a. Patient #2 was a 54 year old male with diagnoses of chronic kidney disease, diabetes, and a history of drug abuse. He was admitted to	V 193	Each member of the interdisciplinary team will meet at a care planning meeting to be held at least monthly. During this meeting, each patient will be individually discussed and given an opportunity to have input into their personalized plan of care. At this time a plan of action and goal will be set for each issue or concern identified. During the month following each care planning meeting each discipline will meet with patients individually to discuss any issues or concerns identified and make a note of their discussion in the interdisciplinary progress notes section of each patient chart at least monthly. This will include the physician, dietician, social worker, and a member of the nursing staff.	11/3/08

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BEAR LAKE DIALYSIS CENTER	164 SOUTH 5TH STREET MONTPELIER, ID 83254

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V 193	Continued From page 11 the facility on 6/30/06 and was currently a patient as of 9/23/08. A psychosocial history, dated 7/19/06, stated the patient had undergone 31 abdominal surgeries and had constant pain. The evaluation said the patient had a history of depression. He also lived alone. A "Case Conference" note, written by the physician and dated 7/8/08, stated the social worker was to evaluate the patient for depression. No progress notes by the social worker in 2008 were present in the record. On 9/25/08 at 12:00 noon, the social worker stated he had helped Patient #2 as much as anyone. The social worker confirmed the patient was depressed but that a specific plan for social services, which addressed Patient #2's needs, had not been developed. b. Patient #4 was an 89 year old male with diagnoses of glomerulonephritis and cardiac problems. He was admitted to the facility on 12/13/06 and was currently a patient as of 9/23/08. The patient's spouse was interviewed on 9/24/08 at 8:15 AM. She stated she drove the patient to the facility. She said they needed assistance with money for transportation. She said the social worker had obtained some assistance for her but that help was sporadic. A plan was not in place to assist the patient with transportation issues, which was confirmed during interview with the social worker on 9/25/08 at 12:00 noon. Additionally, the RN stated, on 9/25/08 at 2:00 PM, that the patient became anxious and had trouble sitting the length of time required to dialyze. The RN stated the patient dialyzed for 3 hours and 15 minutes instead of 4 hours, which was what the physician wanted, because the patient could not tolerate a 4 hour treatment. She confirmed the issue had not been assessed and was not addressed on the POC.	V 193	See Page 11 of 74	

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V 193	Continued From page 12 c. Patient #5 was an 86 year old male with diagnoses of end stage renal disease and long term cardiac disease. He began dialysis at the facility on 6/28/06. His last dialysis treatment occurred on 8/20/08 and he died the following week. On 6/28/07, the patient had surgery for a fractured hip. His current POC, which began in January 2008, stated "Mobility Needs: can't bear wt (without) 2 assist." The plan did not include actions staff were to follow to transfer and position the patient in order to keep him safe and comfortable during dialysis. The plan also stated "Continuous struggle to get pt to come for (treatment) consistently. Having 2 witnesses sign AMA form when he refused & give Epogen SQ." The plan did not assess the reasons the patient refused to come for treatment or suggest ways to assist Patient #5 to accept treatment. A run sheet for Patient #5, dated 6/2708, stated "PT VERY CONFUSED AND GETTING OUT OF HAND WITH STAFF, SWEARING AND YELLING." A run sheet, dated 7/23/08, stated "DURING THE TX, PT BECAME UPSET/AGGRESSIVE/YELLING AT NURSES TO TAKE HIM OFF TX. MUCH REASSURANCE AND ONE ON ONE REQUIRED TO GET HIM TO 3 HOURS." Two other run sheets in August 2008 documented the patient was agitated and asked to leave treatment early. The POC was not updated to assess the behavior and develop and implement actions to decrease Patient #5's anxiety level and prevent recurrences	V 193	See Page 11 of 74	

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V 193	Continued From page 13 of the agitated behaviors, which was confirmed by the RN, who was interviewed on 9/25/08 at 2:00 PM. d. Patient #6 was a 61 year old female with diagnoses of renal failure, diabetes and depression. She began dialyzing at the facility on 5/30/06 and was currently a patient as of 9/23/08. The RN, interviewed on 9/25/08 at 2:00 PM, stated the patient frequently did not present to the facility for dialysis treatments. The RN stated staff had stopped preparing the patient's dialysis machine until the patient was actually in the facility because staff did not know if the patient would come or not. This was not addressed on the patient's POC. In addition, a social service note, dated 7/18/08, stated Patient #6 had talked with a transplant center and needed to lose 40 pounds to be considered for transplant. The note said the patient was going to start on a weight loss program. However, this was not addressed on her POC. e. Patient #7 was a 74 year old male with diagnoses of renal failure and multiple myeloma. Both diagnoses were new to the patient within the last six weeks, according to the patient's wife who was interview on 9/22/08 at 3:00 PM. There was an IDT Patient Plan of Care, initiated 9/08, in the patient's record. All patient needs were standardized by the computer. There was no indication that the patient had been assessed for his psychosocial adjustment to the new diagnoses nor any indication that the patient was assessed for additional needs as a result of the diagnoses.	V 193	See Page 11 of 74	

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V 193	Continued From page 14 f. Patient #8 was a 79 year old female with diagnoses of renal failure and diabetes. She had been dialyzing at the facility since 2006. Her last psychosocial assessment was dated 8/06. No assessment updates had been documented by the social worker for two years. At that time the patient was living with her son and was ambulatory. Since that time, the patient had transferred to a SNF and was wheelchair bound, requiring mechanical assistance for transfers. There had been no contact documented by the social worker since 8/06 to address additional needs associated with the patient's loss of independence and mobility. When interviewed on 9/23/08 at 9:00 AM, the patient stated that she did not know that the facility had a social worker. g. Patient #9 was a 60 year old female with diagnoses of renal failure, diabetes and stroke. She was admitted to the facility on 4/4/08. There was an IDT Patient Plan of Care, initiated 4/7/08, in the patient's record. All patient needs were standardized by the computer. There was not an area where additional needs, inherent to Patient #9, could be addressed. Further review of the record showed Patient #9 had been in a facility during the first two months of dialysis. She then went home, where she lived alone. No additional needs were identified on the care plan reflecting this patient's change in life style, support group or need for assistance with ADLs or medication administration. h. Patient #10 was a 73 year old male with diagnoses of renal failure, diabetes, hypertension and congestive heart failure. He was admitted to the facility on 6/2/08. There was an IDT Patient	V 193	See Page 11 of 74	

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V 193	Continued From page 15 Plan of Care in Patient #10's medical record, initiated 6/2/08. All patient needs were standardized by the computer. Under the area titled "Access Status", a goal was generated by the computer "to maintain functioning and infection free". There was no area to document the individual needs of Patient #10 pertaining to his vascular access. Further, the patient's POC documented he had permanent vascular access placement on 6/29/08. No assessment of this new access or a plan for using this access was included on the care plan. The Nurse Manager was interviewed on 9/25/08 at 2:00 PM. She reviewed the above medical records and confirmed the care plans were not written to address each patient's individual needs. The facility failed to ensure POCs were personalized and included the psychological, social, and functional needs of the patients.	V 193	See Page 11 of 74	
V 195	405.2137(b)(3) PATIENT CARE PLAN: PATIENT INVOLVED The patient, parent, or legal guardian, as appropriate, is involved in the development of the care plan, and due consideration is given to his preferences. This STANDARD is not met as evidenced by: Based on record review, patient interview, and staff interview, it was determined the facility failed to ensure 8 of 9 patients (#s 2 and 4-10), whose records were reviewed, were involved in the development of their POCs. This resulted in the inability of staff to ensure patients' preferences were considered. The findings include: 1. The POCs for Patients #2 and 4-10 were	V 195	Monthly patients will be specifically informed of current issues or concerns identified by the interdisciplinary team and be given the opportunity to address their concerns regarding their treatment and plan of care. Additionally patients will sign the Short Term Care Plan form stating that they have been involved in the care planning process and agree with the plan as it is written. (See attachment 1) Any patient concerns identified will be considered and implemented where possible.	11/3/08

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V 195	Continued From page 16 reviewed and included the following: a. Patient #8 was an 89 year old female with diagnoses of renal failure and diabetes. She was admitted to the facility on 6/5/06. An Interdisciplinary Plan of Care, dated 1/7/08, was included in the clinical record. It contained the patient's signature. However, when the patient was interviewed on 9/23/08 at 8:00 AM, she stated that, "I just let the girls do what they're supposed to". She was not aware of the care planning conference. b. Patient #7 was a 74 year old male with diagnoses that included ESRD, prostatic cancer and Multiple Myeloma. He was admitted to the facility on 8/20/08. An Interdisciplinary Patient Plan of Care, dated 9/08, was found in the clinical record. It documented the patient's signature. However, when the patient's wife was interviewed, on 9/22/08 at 3:00 PM, she stated that she and the patient did not know what a care plan was. It was her understanding that the patient could only eat foods prepared at home from "scratch". c. Patient #4 was an 89 year old male with diagnoses of glomerulonephritis and cardiac problems. He was admitted to the facility on 12/13/06 and was currently a patient as of 9/23/08. The patient's spouse was interviewed on 9/24/08 at 8:15 AM. She stated neither she nor the patient had been included in the development of Patient #4's POC. d. Patient #2 was a 54 year old male with diagnoses of chronic kidney disease, diabetes, and a history of drug abuse. He was admitted to the facility on 6/30/06 and was currently a patient	V 195	See Page 16 of 74	

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V 195	Continued From page 17 as of 9/23/08. This plan contained the patient's signature. However, no documentation that Patient #2 had participated in the development of the plan of care was included in his record. e. Patient #5 was an 86 year old male with diagnoses of end stage renal disease and long term cardiac disease. He began dialysis at the facility on 6/28/06. His last dialysis treatment occurred on 8/20/08 and he died the following week. An Interdisciplinary Patient Plan of Care, dated 1/21/08, was documented in his clinical record. It contained the patient's signature. However, no documentation that Patient #5 had participated in the development of the plan of care was included in his record. f. Patient #6 was a 61 year old female with diagnoses of renal failure, diabetes and depression. She began dialyzing at the facility on 5/30/06 and was currently a patient as of 9/23/08. An Interdisciplinary Patient Plan of Care, dated 1/7/08, was documented in the patient's clinical record. The patient had signed the POC. However, no documentation that Patient #6 had participated in the development of the plan of care was included in her record. g. Patient #9 was a 60 year old female with diagnoses of renal failure, diabetes and stroke. She was admitted to the facility on 3/28/2008. An Interdisciplinary Plan of Care, dated 4/7/08, was included. It contained the patient's signature. However, no documentation that Patient #9 had participated in the development of the plan of care was included in her record h. Patient #10 was a 73 year old male with diagnoses of renal failure, diabetes, hypertension	V 195	See Page 16 of 74	

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V 195	Continued From page 18 and congestive heart failure. He was admitted to the facility on 6/2/2008. An Interdisciplinary Plan of Care, dated 6/2/08, was included. It contained the patient's signature. However, no documentation that Patient #10 had participated in the development of the plan of care was included in his record. When the Nurse Manager was interviewed on 9/25/08 at 1:00 PM, she stated that she obtained the patients' signature after the care conferences had taken place. She also stated that the patients were not invited to the care conferences and that the conferences take place on non-dialysis days. The facility failed to ensure patients were involved in the development of their POCs.	V 195	See Page 16 of 74	
V 230	405.2139 MEDICAL RECORDS The ESRD facility maintains complete medical records on all patients (including self-dialysis patients within the self-dialysis unit and home dialysis patients whose care is under the supervision of the facility) in accordance with accepted professional standards and practices. A member of the facility's staff is designated to serve as supervisor of medical records services, and ensures that all records are properly documented, completed, and preserved and that they are completely and accurately documented, readily available, and systematically organized to facilitate the compilation and retrieval of information. This CONDITION is not met as evidenced by: Based on record review and staff interview it was determined that the facility failed to ensure complete medical records were maintained for 9	V 230		

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V 230	Continued From page 19 of 9 patients (#2-10), whose medical records were reviewed. The cumulative effect of these systemic failures resulted in the inability of the facility to document the care that had been provided to patients. The findings include: 1. Refer to V231 as it relates to the facility's failure to ensure medical records contained sufficient information to document the assessment and treatment provided to patients. 2. Refer to V232 as it relates to the facility's failure to ensure medical records contained documented evidence regarding the assessment of the patients' needs. 3. Refer to V234 as it relates to the facility's failure to ensure patients had written comprehensive POCs. 4. Refer to V241 as it relates to the facility's failure to ensure medical records contained progress notes.	V 230	Bear Lake Dialysis Center has identified the Facility Administrator, Zach Phelps as the supervisor of medical records. Currently he is using a newly developed chart audit system (see attachment 3) to ensure that all required elements are present and orderly in each patient chart and each dialysis prescription is accurate with signed physician orders.	11/6/08
V 231	405.2139(a) MEDICAL RECORDS: IDENTIFY, JUSTIFY, DOCUMENT Each patient's medical record contains sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results accurately. This STANDARD is not met as evidenced by: Based on review of clinical records and staff interview, it was determined the facility failed to ensure medical records contained sufficient information to document the assessment and treatment provided to 7 of 9 patients (#s 2 - 8), whose records were reviewed. The lack of information prevented the facility from providing	V 231	Bear Lake Dialysis Center has identified the Facility Administrator, Zach Phelps as the supervisor of medical records. Currently he is using a newly developed chart audit system (see attachment 3) to ensure that all required elements are present and orderly in each patient chart and each dialysis prescription is accurate with signed physician orders.	11/6/08

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V 231	Continued From page 20 individualized patient treatments and satisfying individual patient needs. The findings include: 1. Patient #2 was a 54 year old male with diagnoses of chronic kidney disease, diabetes, and a history of drug abuse. He was admitted to the facility on 6/30/06 and was currently a patient as of 9/23/08. His record did not include complete information as follows: a. Case Conference notes were hand written. The notes were minimal, not signed, and did not include who was present at the conference. For example, the Case Conference notes for 9/18/08 stated "Doing well 50 PTH"; laboratory results for 5 laboratory values were listed with a question mark after albumin; under the label of BMD (Bone Mineral Density), was documented "improving (illegible) Sensipar (increased) Zemplar"; under the category "Weight gain/loss" the note stated "stable"; blood pressure control and diabetes control were listed as "Good"; under "current medications" was written "added". No signatures or other information were listed on the form. b. Six verbal physician orders for medication changes were documented between 6/6/08 and 8/13/08. None of the orders were signed by the physician. 2. Patient #3 was a 91 year old male with diagnoses of chronic kidney disease and diabetes. He was admitted to the facility on 7/2/08 for his first dialysis ever and was currently a patient as of 9/23/08. Fourteen verbal physician orders for medication changes were documented between 7/2/08 and 9/16/08. None of the orders were signed by the physician.	V 231	See page 20 of 74	

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V 231	Continued From page 21 3. Patient #4 was an 89 year old male with diagnoses of glomerulonephritis and cardiac problems. He was admitted to the facility on 12/13/06 and was currently a patient as of 9/23/08. His record did not include complete information as follows: a. Case Conference notes were hand written. These were minimal, were not signed, and did not include who was present at the conference. b. Eight verbal physician orders for medication changes and other items were documented between 6/9/08 and 8/25/08. None of these orders were signed by the physician. 4. Patient #5 was an 86 year old male with diagnoses of end stage renal disease and long term cardiac disease. He began dialysis at the facility on 6/28/06. His last dialysis treatment occurred on 8/20/08 and he died the following week. His record did not include complete information as follows: a. Three forms titled "Refusal of OR failure to comply with scheduled dialysis treatment" were noted in Patient #5's record. Two of these forms were dated 6/9/08 and 6/13/08. The third form was not dated. No nursing notes were present in the record which documented the events related to the forms including causes, patient assessment, and actions taken. b. Case Conference notes for Patient #5 were hand written. The notes were minimal, were not signed, and did not include who was present at the conference. c. Eight verbal physician orders for medication	V 231	See page 20 of 74	

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V 231	Continued From page 22 changes and other items were documented between 6/6/08 and 8/12/08. None of the orders were signed by the physician. 5. Patient #6 was a 61 year old female with diagnoses of renal failure, diabetes and depression. She began dialyzing at the facility on 5/30/06 and was currently a patient as of 9/23/08. Her record included eight verbal physician orders for medication changes and other items between 6/11/08 and 9/15/08. None of the orders were signed by the physician. 6. Patient #7 was a 74 year old male with diagnoses that included ESRD, prostatic cancer and Multiple Myeloma. He was admitted to the facility on 8/20/2008. His medical record from 8/20/08 to 9/22/08 was reviewed. The record did not include complete information as follows: a. No assessment by the social worker was present in Patient #7's record. b. One case conference note, dated 9/18/08, was found in the clinical record. However, it was not signed and did not include a medication list. 7. Patient #8 was an 89 year old female with diagnoses of renal failure and diabetes. She was admitted to the facility on 6/5/2006. Her medical record from 5/30/08 to 9/22/08 was reviewed. Dietary notes were found only within the case conference. Under the category "fluids," the only action plan for nine consecutive months was to encourage and support fluid restriction. It was documented on individual treatment sheets that the patient consistently left the unit after dialysis 5-6 kilograms over her dry weight, which was a potential indicator that the patient was carrying an	V 231	See Page 20 of 74	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 231	Continued From page 23 excess of fluid, potentially affecting cardio/respiratory functions. 8. Refer to V241 as it relates to the facility's failure to ensure the medical records for Patients #2 and 4-9 contained progress notes.	V 231	See Page 20 of 24	
V 232	405.2139(a) MEDICAL RECORDS: PATIENT ASSESSMENTS All medical records contain documented evidence of assessment of the needs of the patient. This STANDARD is not met as evidenced by: Based on review of clinical records and staff interview, it was determined the facility failed to ensure medical records contained documented evidence of assessment for the needs for 8 of 9 patients (#s 2-5 and 7-10), whose records were reviewed. The lack of current assessments prevented the facility from being able to adequately meet the patient's current needs. 1. Patient #2 was a 54 year old male with diagnoses of chronic kidney disease and diabetes. He was admitted to the facility on 6/30/06 and was currently a patient as of 9/23/08. Patient #2's record did not include assessments of his current needs as follows: a. No documentation of assessing Patient #2's nutritional and dietetic needs, recommending a therapeutic diet, or dietary counseling was present in his record in 2008. Additionally, no dietary progress notes for 2008 were present in the record. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at	V 232	All patients are currently being monitored for dietary, social services, and nursing services needs. Each discipline has developed a specific and individualized patient assessment form (see attachments 6-8) that will be updated at least annually with the patient providing input and direction. The presence of these assessments is also being checked during the monthly chart auditing process. (See attachment 3) Additionally an education record has been instituted in each patient chart that will document when patients receive education from any member of the interdisciplinary team. (See attachment 9)	11/5/08 11/7/08

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V 232	Continued From page 24 least once per month but did not document this well. She said she was not always consistent documenting what dietary handouts she gave to patients. When asked, she stated there were no current patients with documented assessments beyond the restatement of laboratory tests and medication changes. b. No documentation of an assessment of Patient #2's psychosocial needs in 2008 was present in the record. An updated psychosocial evaluation had not been completed since 7/19/06. A "Case Conference" note, written by the physician and dated 7/8/08, stated the social worker was to evaluate the patient for depression. No progress notes by the social worker in 2008 were present in the record. The social worker confirmed the patient was depressed. The social worker said no progress notes had been written in 2008 and no specific social service plan was in place. The social worker said no psychosocial evaluation had been completed since 2006. 2. Patient #3 was a 91 year old male with diagnoses of chronic kidney disease and diabetes. He was admitted to the facility on 7/2/08 for his first dialysis ever and was currently a patient as of 9/23/08. Patient #3's record did not include assessments of his current needs as follows: a. A dietary evaluation was not present in his record. The dietician, interviewed on 9/24/08, at 4:10 PM, stated a dietary evaluation had not been completed. b. A psychosocial evaluation was not present in his record. The social worker, interviewed on 9/25/08 at 12 noon, stated Patient #3's	V 232	See Page 24 of 74	

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V 232	Continued From page 25 psychosocial evaluation had not been completed. 3. Patient #4 was an 89 year old male with diagnoses of glomerulonephritis and cardiac problems. He was admitted to the facility on 12/13/06 and was currently a patient as of 9/23/08. Patient #4's record did not include assessments of his current needs as follows: a. No documentation of assessing Patient #4's nutritional and dietetic needs, recommending a therapeutic diet, or dietary counseling was present in his record in 2008. Additionally, no dietary progress notes for 2008 were present in the record. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at least once per month but did not document this well. She said she was not always consistent documenting what dietary handouts she gave to patients. When asked, she stated there were no current patients with documented assessments beyond the restatement of laboratory tests and medication changes. b. A current social service assessment was not included in his record. The social worker, interviewed on 9/25/08 at 12 noon, stated no progress notes had been written in 2008 and no social service assessment had been done since 2006. The patient was elderly, lived with an elderly spouse and was on a fixed income. He had documented non-compliance, dialyzing an average of 197 minutes each treatment during September, 2008 instead of his ordered 240 minutes per treatment.	V 232	See Page 24 of 74	

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V 232	Continued From page 26 4. Patient #5 was an 86 year old male with diagnoses of end stage renal disease and long term cardiac disease. He began dialysis at the facility on 6/28/06. His last dialysis treatment occurred on 8/20/08 and he died the following week. Patient #5's record did not include assessments of his current needs as follows: a. No documentation of assessing Patient #5's nutritional and dietetic needs, recommending a therapeutic diet, or dietary counseling was present in his record in 2008. Additionally, no dietary progress notes for 2008 were present in the record. The dietician, interviewed on 9/24/08, at 4:10 PM, stated the patient resided in a nursing home and had dietary notes in the nursing home but did not have documentation in the facility notes. b. A current social service assessment was not included in his record. The social worker, interviewed on 9/25/08 at 12 noon, stated Patient #5 was not compliant with his dialysis treatment "over and over again". He stated no progress notes had been written in 2008 and no social service assessment had been done since 2006. 5. Patient #7 was a 74 year old male with diagnoses of renal failure and multiple myeloma.. He had been undergoing dialysis treatments at the facility since August, 2008. Patient #7's record did not include assessments of his current needs as follows: a. There was no documentation that a psychosocial assessment for patient needs had been done since he started dialysis. According to the patient's wife, who was interviewed on 9/22/08 at 3:00 PM, the patient had received both the	V 232	See Page 24 of 74	

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V 232	Continued From page 27 diagnosis of multiple myeloma and renal failure, both life threatening illnesses, in the last six weeks. Assessment was indicated to determine possible psychosocial problems the patient might have had in dealing with these diagnoses. When interviewed on 9/25/08 at 12 noon, the Social Worker confirmed that an initial psychosocial assessment had not been completed for Patient #7. b. There was no documentation that a thorough dietary assessment had been done for Patient #7. During interview on 9/22/08 at 3:00 PM, the patient's wife indicated that she prepared the patient's meals. She had numerous misconceptions about his dietary restrictions. It was her understanding that the patient could only eat foods prepared at home from "scratch". She further stated that she had not consulted with the dietician. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at least once per month but did not document this well. She said she was not always consistent documenting what dietary handouts she gave to patients. When asked, she stated there were no current patients with documented assessments beyond the restatement of laboratory tests and medication changes. 6. Patient #8 was a 79 year old female with diagnoses of renal failure and diabetes. She had been dialyzing at the facility since 2006. Patient #8's record did not include assessments of her current needs as follows: a. Her last psychosocial assessment was dated	V 232	See Page 24 of 74	

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V 232	Continued From page 28 8/2006. No assessment updates had been documented by the social worker for two years. At that time the patient was living with her son and was ambulatory. Since that time, the patient had transferred to a SNF and was wheelchair bound, requiring mechanical assistance for transfers. There had been no contact documented by the Social Worker since 8/2006 to address additional needs associated with the patient's loss of independence and mobility. When interviewed on 9/23/08 at 9:00 AM, the patient stated that she did not know that the facility had a social worker. b. Patient #8's records, dated 5/30/06 to 9/22/08 documented consistent fluid overload. It was documented on individual treatment sheets that the patient consistently left the unit after dialysis 5-6 kilograms over her dry weight, which was a potential indicator that the patient was carrying an excess of fluid, potentially affecting cardio/respiratory functions. However, there was no documentation by the dietician that assessment or patient education had been provided to Patient #8. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at least once per month but did not document this well. She said she was not always consistent documenting what dietary handouts she gave to patients. When asked, she stated there were no current patients with documented assessments beyond the restatement of laboratory tests and medication changes.	V 232	See Page 24 of 74	

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V 232	Continued From page 29 7. Patient #9 was a 60 year old female with diagnoses of renal failure, stroke and diabetes. She was admitted to the facility in March 2008 while she was a hospital inpatient. She was discharged home on an unknown date. Discharge from the hospital occurred sometime between 5/12/08 and 9/15/08. An initial psychosocial assessment, dated 5/12/08, indicated the patient was an inpatient at the hospital. A treatment sheet, dated 9/15/08, indicated the patient arrived from home for her treatment at the facility. There were no reassessments documented by any disciplines, after her discharge home, to evaluate possible increased needs resulting from her change in living situation. 8. Patient #10 was a 73 year old male with diagnoses of renal failure, diabetes and congestive heart failure. He started dialysis treatments at the facility on 6/02/08. Patient #10's record did not include assessments of his current needs as follows: An undated, incomplete dietary assessment was documented in the patient's record. No food preferences, likes or dislikes were noted. Nutritional education said, "handouts to pt. and family" under the headings "diet lab relationship" and "recipes/eating out tips". No further assessment or education notes were documented. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at least once per month but did not document this well. She said she was not always consistent	V 232	See Page 24 of 74	

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V 232	Continued From page 30 documenting what dietary handouts she gave to patients. When asked, she stated there were no current patients with documented assessments beyond the restatement of laboratory tests and medication changes. The facility failed to ensure patient's needs were assessed and updated on a routine basis.	V 232	See Page 24 of 74	
V 234	405.2139(a) MED REC: PCP & LTP All medical records contain the establishment of an appropriate plan of treatment and of the care and services provided (see §405.2137(a) and (b)). This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure there was a comprehensive assessment performed, a POC developed and reassessment of patient outcomes evaluated for 8 of 9 patients (#s 2 and 4-10), whose POCs were reviewed. These failures impeded the facility's ability to adequately meet the patients' needs. The findings include: 1. Patient #2 was a 54 year old male with diagnoses of chronic kidney disease, diabetes, and a history of drug abuse. He was admitted to the facility on 6/30/06 and was currently a patient as of 9/23/08. Patient #2's record did not include documentation of appropriate assessment and planning based on his needs and it did not include documentation of the care and services provided to him as follows: a. Patient #2's record did not include	V 234	All patients are currently being monitored for dietary, social services, and nursing services needs. Each discipline has developed a specific and individualized patient assessment form (see attachments 6-8) that will be updated at least annually with the patient providing input and direction. The presence of these assessments is also being checked during the monthly chart auditing process. (See attachment 3) Interdisciplinary notes are also written at least monthly to follow up. Additionally as part of the chart audit process, all dialysis prescriptions will be checked against written and signed physician orders, including each patients individual Kardex.	11/5/08 11/7/08

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V 234	Continued From page 31 comprehensive psychosocial and dietetic assessment information as follows: - A psychosocial history, dated 7/19/06, stated the patient had undergone 31 abdominal surgeries and had constant pain. The evaluation said the patient had a history of depression. He also lived alone. A "Case Conference" note, written by the physician and dated 7/8/08, stated the social worker was to evaluate the patient for depression. However, Patient #2's record did not include documentation from the social worker which indicated a comprehensive assessment of Patient #2 depression (i.e. symptoms displayed, frequency of symptoms, etc.) had been conducted. The social worker, interviewed on 9/25/08 at 12 noon, confirmed the patient was depressed. The social worker said no psychosocial evaluation had been completed since 2006. - No documentation of assessing Patient #2's nutritional and dietetic needs, recommending a therapeutic diet, or dietary counseling was present in his record in 2008. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at least once per month but did not document this well. Without comprehensive assessment information the facility's ability to establish an appropriate plan of care was impeded. b. Patient #2's record did not include a comprehensive POC as follows: - A "Case Conference" note, written by the physician and dated 7/8/08, stated the social	V 234	See Page 31 of 74	

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V 234	Continued From page 32 worker was to evaluate the patient for depression. However, Patient #2's record did not include care planning related to his depression. The social worker, interviewed on 9/25/08 at 12 noon, stated he had helped Patient #2 as much as anyone. The social worker confirmed the patient was depressed. The social worker said specific social service plan was in place. - Patient #2's POC did not include care planning related to his dietetic needs. The dietician was interviewed on 9/24/08, at 4:10 PM. When asked, she stated there were no current patients with documented specific dietary goals. - A Long Term Program, indicating treatment modality, was dated 12/29/06. It was not signed by a transplant surgeon and there were no subsequent, updated Long Term Programs were present in the patient's medical record. The Nurse Manager was interviewed on 9/25/2008 at 1:00 PM. She confirmed that no updated Long Term Program was found in any of the patients' records. Additionally, the facility administrator was interviewed on 9/25/08 at 4 PM. He stated the long term care plans had not been updated since they were developed. Individual #2's POC did not include comprehensive updated information. c. Individual #2's record did not include comprehensive information related to the care and services he was provided as follows: - No progress notes, documenting the social services he received form the social worker in 2008 were present in Patient #2's record. On 9/25/08 at 12 noon, the social worker stated no	V 234	See Page 31 of 74	

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V 234	Continued From page 33 progress notes had been written in 2008. - The only progress notes by the RN in 2008 were very brief notes on the run sheets such as "vital signs stable" and "no complaints". The notes did not contain comprehensive information related to the nursing care and services he had received. - Weekly notes were included in Patient #2's record. The first note of each month was labeled "Comprehensive visit" with others labeled "(Follow up) visit". The notes described Patient #2's physical condition. The notes were not signed and did not indicate who had written them. When interviewed on 9/25/08 at 10:30 AM, the facility's Medical Director stated he had written the notes. - The dietician's notes in 2008, documented monthly on the "Interdisciplinary Plan of Care" form, only restated laboratory values and noted medication changes. The notes were not signed. None of these notes documented what the patient was eating or drinking or dietary suggestions and no additional dietary progress notes for 2008 were present in the record. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at least once per month but did not document this well. She said she was not always consistent documenting what dietary handouts she gave to patients. When asked, she stated there were no current patients with documented specific dietary goals. The facility failed to ensure Patient #2's record included comprehensive documentation of appropriate planning based on his needs and	V 234	See Page 31 of 74	

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V 234	Continued From page 34 documentation of the care and services he was provided with. 2. Patient #4 was an 89 year old male with diagnoses of glomerulonephritis and cardiac problems. He was admitted to the facility on 12/13/06 and was currently a patient as of 9/23/08. a. Patient #4's record did not include comprehensive psychosocial and dietetic assessment information as follows: - No documentation of assessment for Patient #4's nutritional and dietetic needs, recommending a therapeutic diet, or dietary counseling was present in his record in 2008. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at least once per month but did not document this well. She said she was not always consistent documenting what dietary handouts she gave to patients. When asked, she stated there were no current patients with documented assessments beyond the restatement of laboratory tests and medication changes. - A current social service assessment was not included in Patient #4's record. A psychosocial history, dated 1/4/07 documented no psychosocial problems. The RN, interviewed on 9/25/08 at 2 PM, stated the physician wanted the patient to dialyze for 4 hours but the patient refused and would only dialyze for 3 hours and 15 minutes. The patient's wife, interviewed on 9/24/08 at 8:15 AM., stated the patient often became anxious during dialysis treatments and	V 234	See Page 31 of 74	

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V 234	Continued From page 35 she had to go sit with him to calm him down. She also stated they needed assistance with money for transportation. The social worker, interviewed on 9/25/08 at 12 noon, stated no progress notes had been written in 2008 and no social service assessment had been done since 2007. Without comprehensive assessment information the facility's ability to establish an appropriate plan of care was impeded. b. Patient #4's record did not document the development of a comprehensive POC as follows: - A Long Term Program, indicating treatment modality and transplant status, was dated 12/29/06. It was not signed by the social worker or the transplant surgeon. No subsequent, updated Long Term Programs were present in the patient's medical record. - The patient's spouse was interviewed on 9/24/08 at 8:15 AM. She stated neither she nor the patient had been included in the development of Patient #4's POC. - The patient's spouse was interviewed on 9/24/08 at 8:15 AM. She stated she drove the patient to the facility. She said they needed assistance with money for transportation. She said the social worker had obtained some assistance for her but that help was sporadic. A plan was not in place to assist the patient with transportation issues, which was confirmed during interview with the social worker on 9/25/08 at 12 noon.	V 234	See Page 31 of 74	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 234	Continued From page 36 The social worker, interviewed on 9/25/08 at 12 noon, stated he had helped Patient #4 with money for transportation. He also stated a specific plan for social services, which addressed Patient #4's needs, had not been developed. Additionally, the RN stated, on 9/25/08 at 2 PM, that the patient became anxious and had trouble sitting the length of time required to dialyze. She said the patient dialyzed for 3 hours and 15 minutes instead of 4 hours, which is what the physician wanted, because the patient could not tolerate a 4 hour treatment. She confirmed this issue had not been assessed and was not addressed on the POC. Patient #4's record did not contain a comprehensive POC. c. Patient #4's record did not include documentation of updated, comprehensive information related to the care and services he was provided as follows: - The dietician's notes in 2008, documented monthly on the "Interdisciplinary Plan of Care" form, restated laboratory values and noted medication changes. The notes were not signed. None of the notes documented what the patient was eating or drinking or dietary suggestions. No dietary progress notes for 2008 were present in the record. - Case Conference notes were hand written. These were minimal, were not signed, and did not include who was present at the conference. - No progress notes by the social worker were	V 234	See Page 31 of 74	

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V 234	Continued From page 37 present in the record for 2008. When interviewed on 9/25/08 ay 1:00 PM, the social worker confirmed that no progress notes were documented during 2008. - The only progress notes by the RN in 2008 were very brief notes on the run sheets such as "vital signs stable" and "no complaints". The Nurse Manager was interviewed on 9/25/2008 at 2:00 PM. She reviewed the medical record and confirmed the omissions. - Eight verbal physician orders for medication changes and other items were documented between 6/9/08 and 8/25/08. None of these orders were signed by the physician indicating the MD was aware of changes in the patient's condition. - Weekly notes were included in the record. The first note of each month was labeled "Comprehensive visit" with others labeled "(Follow up) visit". The notes described Patient #4's physical condition. The notes were not signed and did not indicate who had written them. When interviewed on 9/25/08 at 10:30 AM, the facility's Medical Director stated he had written the notes. Patient #4's record did not contain evidence that the patient's outcomes had been examined and reassessed. The facility failed to ensure Patient #4's record included comprehensive documentation of appropriate planning based on his needs and documentation of the care and services he was provided with. 3. Patient #5 was an 86 year old male with	V 234	See Page 31 of 74	

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V 234	Continued From page 38 diagnoses of end stage renal disease and long term cardiac disease. He began dialysis at the facility on 6/28/06. His last dialysis treatment occurred on 8/20/08 and he died the following week. a. Patient #5's record did not include comprehensive assessments in the following areas: - A current social service assessment was not included in Patient #5's record. A psychosocial history was dated 7/26/06. An updated psychosocial evaluation had not been completed since that date. The social worker, interviewed on 9/25/08 at 12 noon, stated Patient #5 was not compliant with his dialysis treatment "over and over again". He stated no social service assessment had been done since 2006. - No documentation of assessing Patient #5's nutritional and dietetic needs, recommending a therapeutic diet, or dietary counseling was present in his record in 2008. The dietician, interviewed on 9/24/08, at 4:10 PM, stated the patient resided in a nursing home and had dietary notes in the nursing home but did not have documentation in the facility notes. Without comprehensive assessment information the facility's ability to establish an appropriate POC was impeded. b. Patient #5's record did not document the development of a comprehensive POC as follows:	V 234	See Page 31 of 34	

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V 234	Continued From page 39 - A Long Term Program, indicating treatment modality, was dated 12/20/06. It was not signed by the dietician or the transplant surgeon. No subsequent, updated Long Term Programs were present in the patient's medical record. - On 6/28/07, the patient had surgery for a fractured hip. His current POC, which began in January 2008, stated "Mobility Needs: can't bear wt (without) 2 assist". The plan did not include actions staff were to take to transfer and position the patient in order to keep him safe and comfortable during dialysis. - The plan also stated "Continuous struggle to get pt to come for (treatment) consistently. Having 2 witnesses sign AMA form when he refuses & give Epogen SQ." The plan did not assess the reasons the patient refused to come for treatment or suggest ways to assist the patient to accept treatment. - A run sheet for Patient #5, dated 6/27/08, stated, "PT VERY CONFUSED AND GETTING OUT OF HAND WITH STAFF, SWEARING AND YELLING." A run sheet, dated 7/23/08, stated "DURING THE TX, PT BECAME UPSET/AGGRESSIVE/YELLING AT NURSES TO TAKE HIM OFF TX. MUCH REASSURANCE AND ONE ON ONE REQUIRED TO GET HIM TO 3 HOURS." Two other run sheets in August 2008 documented the patient was agitated and asking to leave treatment early. The POC did not develop and implement actions to decrease Patient #5's anxiety level and prevent recurrences of the agitated behaviors, which was confirmed by the RN, who was interviewed on 9/25/08 at 2 PM. The social worker, interviewed on 9/25/08 at 12	V 234	See Page 31 of 74	

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V 234	Continued From page 40 noon, stated Patient #5 was not compliant with his dialysis treatment "over and over again." He confirmed no specific social service plan was in place. Patient #5's record did not document the development of a comprehensive POC. c. Patient #5's record did not include documentation of updated, comprehensive information related to the care and services he was provided as follows: - Case Conference notes for Patient #5 were hand written. The notes were minimal, were not signed, and did not include who was present at the conference. - Three forms titled "Refusal of OR failure to comply with scheduled dialysis treatment" were noted in Patient #5's record. Two of these forms were dated 6/9/08 and 6/13/08. The third form was not dated. No nursing notes were present in the record which documented the events related to the forms including causes, patient assessment, and actions taken. - Only 2 nursing progress notes were included in the patient record in 2008 (dated 7/21 and 7/23/08). Both progress notes involved a procedure the patient was having done. The Nurse Manager was interviewed on 9/25/2008 at 2:00 PM. She reviewed the above medical record and confirmed the omissions. - Eight verbal physician orders for medication changes and other items were documented between 6/6/08 and 8/12/08. None of the orders were signed by the physician.	V 234	See Page 31 of 74	

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V 234	Continued From page 41 - Weekly notes were included in Patient #5's record. The first note of each month was labeled "Comprehensive visit" with others labeled "(Follow up) visit". The notes described the patient's physical condition. The notes were not signed and did not indicate who had written them. When interviewed on 9/25/08 at 10:30 AM, the facility's Medical Director stated he had written the notes. - No progress notes by the social worker in 2008 were present in the record. The social worker, interviewed on 9/25/08 at 12 noon, stated Patient #5 was not compliant with his dialysis treatment "over and over again. He confirmed no progress notes had been written in 2008 and no specific social service plan was in place. - No dietary progress notes for 2008 were present in the record. The dietician, interviewed on 9/24/08, at 4:10 PM, stated the patient resided in a nursing home and had dietary notes in the nursing home but did not have documentation in the facility notes. Patient #5's record did not contain documentation that the patient's outcomes had been reassessed. The facility failed to ensure Patient #5's record included comprehensive documentation of appropriate planning based on his needs and documentation of the care and services he was provided with. 4. Patient #6 was a 61 year old female with diagnoses of renal failure, diabetes and depression. She began dialyzing at the facility on 5/30/06 and was currently a patient as of 9/23/08.	V 234	See Page 31 of 74	

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V 234	Continued From page 42 a. Patient #6's record did not include the development of a comprehensive POC as follows: - The RN, interviewed on 9/25/08 at 2 PM, stated the patient frequently did not present to the facility for dialysis treatments. She stated staff had stopped preparing the patient's dialysis machine until the patient was actually in the facility because staff did not know if the patient would come or not. This was not addressed on the patient's POC. Additionally, a social service note, dated 7/18/08, stated Patient #6 had talked with a transplant center and needed to lose 40 pounds to be considered for transplant. The note said the patient was going to start on a weight loss program. However, this was not addressed on her POC. The Social Worker was interviewed on 9/25/08 at 12 noon. He stated no specific social service plan had been developed for this patient. - A Long Term Program, indicating treatment modality, was dated 12/20/06. It was not signed by a transplant surgeon. No subsequent, updated Long Term Programs were present in the patient's medical record. - An Interdisciplinary Patient Plan of Care, dated 1/7/08, was documented in the patient's clinical record. The patient had signed the POC. However, no documentation that Patient #6 had participated in the development of the plan of care was included in her record. b. Patient #6's record did not include comprehensive, updated information related to the care and services she was provided as	V 234	See Page 31 of 74	

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V 234	Continued From page 43 follows: - Her record included eight verbal physician orders for medication changes and other items between 6/11/08 and 9/15/08. None of the orders were signed by the physician. - Weekly notes were included in the record. The first note of each month was labeled "Comprehensive visit" with others labeled "(Follow up) visit". The notes described Patient #6's physical condition. The notes were not signed and did not indicate who had written them. When interviewed on 9/25/08 at 10:30 AM, the facility's Medical Director stated he had written the notes. - Two social service notes were present in the record. The first note, dated 10/29/07, stated the patient had been knitting and crocheting. It said she was more open than in the past and "compliance seems a bit better". The note also stated the social worker was waiting on lab "test to see (blood sugar) compliance over time". On 7/18/08 a social service note stated the patient had talked with a transplant center and needed to lose 40 pounds to be considered for transplant. The note said the patient was going to start on a weight loss program. The note further stated the patient was receiving financial assistance for transportation. Note did not address compliance or depression. The Social Worker confirmed no social service progress notes were present in the record for 2008, except for the 7/18/08 note, when he was interviewed on 9/25/08 at 12 noon. - No progress notes by the dietician were present in the record for 2008. A social service note, dated 7/18/08, stated the patient had talked with a transplant center and needed to lose 40 pounds	V 234	See Page 31 of 74	

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V 234	Continued From page 44 to be considered for transplant. The note said the patient was going to start on a weight loss program. This was not documented by the dietician and no plan was documented for the patient to lose weight. The facility failed to ensure the documentation of the care and services provided to Patient #6. The facility failed to ensure Patient #6's record included comprehensive documentation of appropriate planning based on her needs and documentation of the care and services she was provided with. 5. Patient #7 was a 74 year old male with diagnoses of renal failure and multiple myeloma. He had been undergoing dialysis treatments at the facility since August, 2008. a. Patient #7's record did not include evidence of a comprehensive assessment in the following areas: - There was no documentation that a psychosocial assessment for patient needs had been done since Patient #7 started dialysis. When interviewed on 9/25/08 at 12 noon, the Social Worker confirmed that an initial psychosocial assessment had not yet been done for Patient #7. - There was no documentation that a thorough dietary assessment had been done for Patient #7. During interview on 9/22/08 at 3:00 PM, the patient's wife indicated that she prepared the patient's meals. She had numerous misconceptions about his dietary restrictions. It was her understanding that the patient could only	V 234	See Page 31 of 74	

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V 234	Continued From page 45 eat foods prepared at home from "scratch". She further stated that she had not consulted with the dietician. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at least once per month but did not document this well. She said she was not always consistent documenting what dietary handouts she gave to patients. When asked, she stated there were no current patients with documented specific dietary goals. The facility failed to ensure comprehensive assessment was done for Patient #7. b. Patient #7's record did not establish that a comprehensive patient POC had been developed as follows: - There had been no contact with social services as of the date of survey on 9/22/08. The patient had been receiving dialysis services for over thirty days at that time, and had experienced more than one life changing event just prior to his admission, creating additional psychosocial needs. There was no specific psychosocial care plan in place for this patient. The social worker, interviewed on 9/25/08 at 12 noon, stated a specific plan for social services, which addressed Patient #7's needs, had not been developed. - POC notes pertaining to dietary issues did not develop a plan for the patient. Under the heading "Bones", there was no plan stated. Under the heading "Nutrition," the plan stated, "goal Alb>4.0" with no plan as to how this would be	V 234	See Page 31 of 74	

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V 234	Continued From page 46 achieved. Under the heading "Potassium," the plan stated, "monitor K+ food intake/ K+ bath" with no specific action as to how food/K+ bath would be monitored or what actions would be taken. - A Long Term Program, indicating treatment modality, was dated 8/20/2008. It was not signed by a physician, a dietician or a transplant surgeon documenting their involvement in the development of the Program. - An Interdisciplinary Patient Plan of Care, dated 9/08, was found in the clinical record. It documented the patient's signature. However, when the patient's wife was interviewed, on 9/22/08 at 3:00 PM, she stated that she and the patient did not know what a care plan was. It was her understanding that the patient could only eat foods prepared from "scratch". - Patient #7's record included an MD order, dated 8/20/2008, which called for a dialyzer size F160. On the Kardex, which was used to set up for daily treatments, the POC called for using a F200 size dialyzer. There was no MD order found for the change in dialyzer size. Additionally, an MD order, dated 8/20/2008, called for use of a 2K/2.5Ca dialysate bath. However, the Kardex, reflecting the POC, showed a 3K/2.5Ca dialysate bath was being used. There was no MD order found for a change in the dialysate bath. Because of deficient care planning, the patient was not receiving dialysis treatments as prescribed by the doctor. c. Patient #7's record did not show that his outcome were assessed, nor does it show the care and services he was receiving as follows:	V 234	See Page 31 of 74	

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V 234	Continued From page 47 - One case conference note, dated 9/18/08, was found in the clinical record. it vaguely described the patient's physical condition. However, it was not signed and did not include a medication list. - No nursing progress notes were present in Patient #7's record. The Nurse Manager was interviewed on 9/25/2008 at 2:00 PM. She reviewed the above medical record and confirmed the omissions. - Dietician progress notes, recorded in the case conference dated 9/1/08 consisted of, "monitor K+ foods" and "does not gain much/occ loss or same wt." Patient #7's serum phosphorus level was marked as "NA" on the care conference. Information related to what Patient #7 was eating or drinking or dietary suggestions were not included on the notes. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at least once per month but did not document this well. She said she was not always consistent documenting what dietary handouts she gave to patients. When asked, she stated there were no current patients with documented specific dietary goals. - Patient #7's record showed initial dialysis MD orders, dated 8/20/08, as well as 6 subsequent MD orders written between 8/20/08 and 9/19/08 that were unsigned. The facility failed to ensure the record of Patient #7 included comprehensive documentation of appropriate planning based on his needs, and	V 234	See Page 31 of 74	

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V 234	Continued From page 48 documentation of the care and services he was provided with. 6. Patient #8 was an 89 year old female with diagnoses of renal failure and diabetes. She was admitted to the facility on 6/5/2006. a. Patient #8's record did not include comprehensive assessments in the following areas: - Patient #8 had a Social Services assessment on 8/25/06. At that time the patient was living with her son and was ambulatory. Since that time, the patient had transferred to a SNF and was wheelchair bound, requiring mechanical assistance for transfers. There was no contact documented by the Social Worker since 8/2006 to address additional needs associated with the patient's loss of independence and mobility. When interviewed on 9/23/08 at 9:00 AM, the patient stated that she did not know that the facility had a social worker. The social worker, interviewed on 9/25/08 at 12 noon, confirmed that there were no psychosocial reassessments present in the chart since 2006. - No documentation of assessment of this patient's nutritional and dietetic needs, recommending a therapeutic diet, or dietary counseling was present in her record in 2008. The dietician, interviewed on 9/24/08, at 4:10 PM, stated the patient resided in a nursing home and had dietary notes in the nursing home but did not have documentation in the facility notes. Patient #8 did not have appropriate assessments documented in her clinical record. This failure prevented the facility from meeting the patient's	V 234	See Page 31 of 74	

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V 234	Continued From page 49 current needs. b. Patient #8's record did not contain documentation of a comprehensive POC as follows: - A Long Term Program, indicating treatment modality, was dated 6/5/2006. It did not contain the signatures of a social worker or a transplant surgeon documenting their involvement in the development of the Program. No subsequent, updated Long Term Programs were present in the patient's medical record. - An Interdisciplinary Patient Plan of Care, dated 1/7/08, was included in the clinical record. It contained the patient's signature. However, when the patient was interviewed on 9/23/08 at 8:00 AM, she stated that "I just let the girls do what they're supposed to". She was not aware of the care planning conference. When the Nurse Manager was interviewed on 9/25/08 at 1:00 PM, she stated that she obtained the patients' signatures after the care conferences had taken place. She also stated that the patients were not invited to the care conferences and that the care conferences take place on non-dialysis days. - The social worker, interviewed on 9/25/08 at 12 noon, stated a specific plan for social services, which addressed Patient #8's changing needs, had not been developed. - On Patient #8's POC, under the heading "Nutrition", a goal of "Albumin > 3.5" was stated. There was no plan developed as to how this would be achieved. Another note stated "pt. lives	V 234	See Page 31 of 74	

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V 234	Continued From page 50 in SNF. Diet/meals/protein supplements directed by dietician". The patient's Albumin level had been recorded below 3.5 for the past nine months with no action documented to correct this. c. Patient #8's record did not contain documentation of updated, comprehensive information related to the care and services she was provided as follows: - Dietary notes were found only within the case conference. Under the category "fluids," the only action plan for nine consecutive months was to encourage and support fluid restriction. There was no documentation that the care plan had been changed or the patient had been educated. It was documented on individual treatment sheets that the patient consistently left the unit after dialysis 5-6 kilograms over her dry weight, which was a potential indicator that the patient was carrying an excess of fluid, potentially affecting cardio/respiratory functions. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at least once per month but did not document this well. She said she was not always consistent documenting what dietary handouts she gave to patients. When asked, she stated there were no current patients with documented assessments beyond the restatement of laboratory tests and medication changes. - Nursing notes consisted only of brief remarks on the run sheets such as "pt. sleeping" and "vital signs stable". The Nurse Manager was interviewed on 9/25/2008 at 2:00 PM. She reviewed the above medical record and	V 234	See Page 31 of 74	

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V 234	Continued From page 51 confirmed the omissions. - There were no Social Service progress notes documented. The social worker, interviewed on 9/25/08 at 12 noon, stated a specific plan for social services, which addressed Patient #8's needs, had not been developed. - Weekly notes were included in Patient #8's record. The first note of each month was labeled "Comprehensive visit" with others labeled "(Follow up) visit". The notes described the patient's physical condition. The notes were not signed and did not indicate who had written them. When interviewed on 9/25/08 at 10:30 AM, the facility's Medical Director stated he had written the notes. The facility failed to ensure Patient #8's record included comprehensive documentation of appropriate planning based on her needs, and documentation of the care and services she was provided with. 7. Patient #9 was a 60 year old female with diagnoses of renal failure, diabetes and stroke. She was admitted to the facility on 3/28/2008. a. Patient #9's record did not contain documentation of a comprehensive POC as follows: - A Long Term Program, indicating treatment modality, was dated 4/4/2008. It did not contain the signatures of a physician, a social worker, a dietician or a transplant surgeon documenting their involvement in the development of the Program. - There was an IDT Patient Plan of Care, initiated	V 234	See page 31 of 74	

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V 234	Continued From page 52 4/7/08, in the patient's record. All patient needs were standardized by the computer. There was not an area where additional needs, inherent to Patient #9, could be addressed. b. Patient #9's record did not contain documentation of updated, comprehensive information related to the care and services she was provided as follows: - Review of the record showed Patient #9 had been in a facility during the first two months of dialysis. She then went home, where she lived alone. No additional needs were identified on the care plan reflecting this patient's change in life style, support group or need for assistance with ADLs or medication administration. - Interdisciplinary Progress Notes were found in the patient's record on 5/19/08 addressing placement of a permanent access, which was placed on 5/21/08. POC notes, dated 5/19/08, under the heading "other" included a goal of "get access placed and matured. Get pt's CVC removed ASAP". There was no other plan documented after that date. Another Interdisciplinary Progress Note, dated 5/23/08, documented a phone call with a transplant center. No definitive plan was found in the patient's POC referencing further progression of the transplant work up. When the Director of Nursing was interviewed on 9/25/08 at 1:00 PM, she stated that nothing further had been done toward obtaining the patient a transplant work up. She also stated that the patient was resisting the use of needles in the new access. This issue had not been addressed by the Interdisciplinary Team.	V 234	See page 31 of 74	

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V 234	Continued From page 53 - MD orders, dated 4/4/2008, stated a treatment time of 3.75 hours three times a week. On 5/3/2008 an MD order indicating a "one time only" change in treatment time to 3 hours was documented. Review of treatment sheets showed the patient's treatment time had remained at 3 hours since the time of the 5/3/08 MD order. The Kardex, used for daily treatments, indicated a dialyzer size of F160. An MD order, dated 7/15/2008, called for a change in dialyzer size to an F200. Also, an MD order, dated 4/4/2008, called for a dialysate bath strength of 3K/2.5Ca. An MD order, dated 8/11/2008, stated that a 1K/ 2.5Ca dialysate bath be used for treatment "one time only". The Kardex and review of daily treatment sheets showed that a 1K/ 2.5Ca dialysate bath was continued until the date of review, 9/24/2008. There was no subsequent MD order, after 8/11/08, indicating the continued use of the 1K/2.5Ca dialysate bath. The POC did not reflect the changes in the dialysis prescription. - A psychosocial assessment was done at the time of admission when the patient was an inpatient at the hospital. No contact or follow up by the Social Worker was documented when the patient was discharged home, where she lived alone, to address additional patient needs associated with this change. Further, a Social Worker note was included in the Case Conference, dated 8/15/08. It said "relatives stated worried about depression". The Social Worker wrote that he had notified the doctor. His plan of action consisted of "wait and see if M.D. prescribes". No further notes were documented about the outcome for the patient or	V 234	See page 31 of 74	

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V 234	Continued From page 54 other intervention by the Social Worker on the patient's behalf. When the Social Worker was interviewed on 9/25/08 at 12 noon, he stated he had worked with Patient #9 on several issues, but confirmed that there were no Progress Notes to document these activities. - Patient #9's initial dietary assessment was done while she was a patient in the hospital. The patient was malnourished at the time of her admission to the dialysis facility, as documented by laboratory values that showed an Albumin level of 2.4. Acceptable Albumin level was 3.5 or higher. No dietary progress notes were present in the record after the initial assessment. She was later discharged home, where she lived alone. No documentation was present in her record showing dietary reassessment for potential problems that may have been present as a result of the change, such as the patient's ability to obtain groceries and prepare adequate meals. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at least once per month but did not document this well. She said she was not always consistent documenting what dietary handouts she gave to patients. When asked, she stated there were no current patients with documented assessments beyond the restatement of laboratory tests and medication changes. The facility failed to ensure Patient #9's record included comprehensive documentation of appropriate planning based on her needs, and documentation of the care and services she was provided with.	V 234	See page 31 of 74	

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V 234	Continued From page 55 8. Patient #10 was a 73 year old male with diagnoses of renal failure, diabetes and congestive heart failure. He started dialysis treatments at the facility on 6/02/08. a. Patient #10's record did not include comprehensive assessment information as follows: - An undated, incomplete dietary assessment was documented in the patient's record. No food preferences, likes or dislikes were noted. Nutritional education said, "handouts to pt. and family" under the headings "diet lab relationship" and "recipes/eating out tips". No further assessment or education notes were documented. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at least once per month but did not document this well. She said she was not always consistent documenting what dietary handouts she gave to patients. When asked, she stated there were no current patients with documented assessments beyond the restatement of laboratory tests and medication changes. b. Patient #10's record did not contain documentation of a comprehensive POC as follows: - On the patient's POC under the heading "Pain", it was documented that the "pt. usually has c/o pain back/hips". The plan stated "Assess pain with each/tx, provide comfort measures". No comfort measures were recommended. For four months, the POC action was listed as "cont. to	V 234	See page 31 of 74	

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V 234	Continued From page 56 assess pain". There were no recommendations as to pain relief measures and no indication that the patient had decreased pain. - MD orders, dated 6/2/08, indicated a dialysate flow rate of 600ml/minute. The Kardex, updated on 9/19/08 and used for daily treatment parameters, indicated dialysate flow rate of 800ml/minute. No MD order, indicating a change in the dialysate flow rate, was documented. The POC was not comprehensive in that it did not reflect the dialysis prescription. MD orders, dated 6/2/08, did not specify a dialysate bath strength. A treatment sheet, dated 6/2/08, indicated a 3K/2.5Ca dialysate bath was used for the patient's treatment. The Interdisciplinary Patient Care Plan, dated 7/7/08, noted the patient was being treated with a 1K/2.5Ca dialysate bath. The Interdisciplinary Patient Care Plan, dated 9/3/08, stated the patient was being treated with a 2K/2.5Ca dialysate bath. Individual run sheets, dated 9/10 through 9/24/08 indicated the patient was being treated with a 1K/2.5Ca dialysate bath. There were no MD orders documented during the time period 6/2/08 until 9/24/08 ordering a dialysate bath strength or a change in the dialysate bath strength. The POC did not reflect the prescribed dialysis prescription. The Nurse Manager was interviewed on 9/25/08 at 2:00 PM. She reviewed Patient #10's medical record and confirmed that care plans were not written according to MD prescription. - When the patient's clinical record was reviewed, an Interdisciplinary Patient Plan of Care, dated 6/2/08, was included. It contained the patient's	V 234	See page 31 of 74	

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V 234	Continued From page 57 signature. However, no documentation that Patient #10 had participated in the development of the plan of care was included in his record. When the Nurse Manager was interviewed on 9/25/08 at 1:00 PM, she stated that she obtained the patients' signatures after the care conferences had taken place. She also stated that the patients were not invited to the care conferences and that the care conferences take place on non-dialysis days. The facility failed to ensure a comprehensive POC was developed for Patient #10. c. Patient #10's record did not contain documentation of updated, comprehensive information related to the care and services he was provided as follows: - An initial psychosocial assessment was done when he began dialysis treatments at the facility (6/25/07). Patient #10's record did not include an updated assessment or social work notes since that date. The social worker, interviewed on 9/25/08 at 12 noon, stated a specific plan for social services, which addressed Patient #8's needs, had not been developed. - There were no dietary Progress Notes documented in Patient #10's record. Dietician documentation consisted of copying laboratory values onto the POC. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at least once per month but did not document this well. She said she was not always consistent documenting what dietary handouts she gave to patients. When asked, she	V 234	See page 31 of 74	

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V 234	Continued From page 58 stated there were no current patients with documented assessments beyond the restatement of laboratory tests and medication changes. There was no documentation of updated, comprehensive information related to the care and services Patient #10 was provided.	V 234	See page 31 of 74	
V 241	405.2139(a) MEDICAL RECORD: PROGRESS NOTES All medical records contain observations and progress notes. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility to ensure medical records contained progress notes for 6 of 9 patients (#s 2 and 4 - 9), whose medical records were reviewed. This resulted in the inability of the facility to show evidence of treatment that had been provided to patients. The findings include: 1. Patient #2 was a 54 year old male with diagnoses of chronic kidney disease, diabetes, and a history of drug abuse. He was admitted to the facility on 6/30/06 and was currently a patient as of 9/23/08. His record did not include complete progress notes as follows: a. No progress notes by the social worker were present in the record for 2008. b. The only progress notes by the RN in 2008 were very brief notes on the run sheets such as "vital signs stable" and "no complaints". c. The dietician's notes in 2008, documented	V 241	Each discipline will meet and discuss each patient's current situation with them and document any issues or concerns identified in the interdisciplinary progress notes at least monthly. This is to include the physician, dietary, social services, and nursing.	11/3/08

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V 241	Continued From page 59 monthly on the "Interdisciplinary Plan of Care" form, only restated laboratory values and noted medication changes. The notes were not signed. None of these notes documented what the patient was eating or drinking or dietary suggestions. d. Weekly notes were included in Patient #2's record. The first note of each month was labeled "Comprehensive visit" with others labeled "(Follow up) visit". The notes described Patient #2's physical condition. The notes were not signed and did not indicate who had written them. When interviewed on 9/25/08 at 10:30 AM, the facility's Medical Director stated he had written the notes. The Nurse Manager was interviewed on 9/25/2008 at 2:00 PM. She reviewed the above medical records and confirmed the omissions. 2. Patient #4 was an 89 year old male with diagnoses of glomerulonephritis and cardiac problems. He was admitted to the facility on 12/13/06 and was currently a patient as of 9/23/08. His record did not include complete progress notes as follows: a. No progress notes by the social worker were present in the record for 2008. b. The only progress notes by the RN in 2008 were very brief notes on the run sheets such as "vital signs stable" and "no complaints". c. The dietician's notes in 2008, documented monthly on the "Interdisciplinary Plan of Care" form, restated laboratory values and noted medication changes. The notes were not signed. None of the notes documented what the patient was eating or drinking or dietary suggestions.	V 241	See page 59 of 74	

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V 241	Continued From page 60 d. Weekly notes were included in the record. The first note of each month was labeled "Comprehensive visit" with others labeled "(Follow up) visit". The notes described Patient #4's physical condition. The notes were not signed and did not indicate who had written them. When interviewed on 9/25/08 at 10:30 AM, the facility's Medical Director stated he had written the notes. The Nurse Manager was interviewed on 9/25/2008 at 2:00 PM. She reviewed the above medical records and confirmed the omissions. 3. Patient #5 was an 86 year old male with diagnoses of end stage renal disease and long term cardiac disease. He began dialysis at the facility on 6/28/06. His last dialysis treatment occurred on 8/20/08 and he died the following week. His record did not include complete progress notes as follows: a. Three forms titled "Refusal of OR failure to comply with scheduled dialysis treatment" were noted in Patient #5's record. Two of these forms were dated 6/9/08 and 6/13/08. The third form was not dated. No nursing notes were present in the record which documented the events related to the forms including causes, patient assessment, and actions taken. b. Only 2 nursing progress notes were included in the patient record in 2008 (dated 7/21 and 7/23/08). Both progress notes involved a procedure the patient was having done. The RN confirmed the lack of nursing notes in the record when interviewed on 9/25/08 at 2 PM. c. Weekly notes were included in Patient #5's	V 241	See page 59 of 70	

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V 241	Continued From page 61 record. The first note of each month was labeled "Comprehensive visit" with others labeled "(Follow up) visit". The notes described the patient's physical condition. The notes were not signed and did not indicate who had written them. When interviewed on 9/25/08 at 10:30 AM, the facility's Medical Director stated he had written the notes. The Nurse Manager was interviewed on 9/25/2008 at 2:00 PM. She reviewed the above medical records and confirmed the omissions. 4. Patient #6 was a 61 year old female with diagnoses of renal failure, diabetes and depression. She began dialyzing at the facility on 5/30/06 and was currently a patient as of 9/23/08. Her record did not include complete progress notes as follows: a. The social worker, interviewed on 9/25/08 at 12 noon, stated he had worked on several issues with Patient #6. However, only 2 social service notes were present in Patient #6's record between 9/23/07 and 9/23/08. The first note, dated 10/29/07, stated the patient had been knitting and crocheting. It said she was more open than in the past and "compliance seems a bit better".. The note also stated the social worker was waiting on lab "test to see (blood sugar) compliance over time". The 7/18/08 social service note stated the patient had talked with a transplant center and needed to lose 40 pounds to be considered for transplant. The note said the patient was going to start on a weight loss program. The note further stated the patient was receiving financial assistance for transportation. The social worker confirmed no social service notes were present in the record for 2008 except for the 2 above mentioned notes.	V 241	See page 59 of 70	

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V 241	Continued From page 62 5. Patient #8 was an 89 year old female with diagnoses of renal failure and diabetes. She was admitted to the facility on 6/5/2006. The record did not include complete information as follows: a. Nursing notes consisted only of brief remarks on the run sheets such as "pt. sleeping" and "vital signs stable". b. There were no dietary progress notes documented. c. There were no Social Service progress notes documented. d. The MD progress notes for the months of June, July and August 2008 remained unsigned. 6. Patient #9 was a 60 year old female with diagnoses of renal failure, diabetes and stroke. She was admitted to the facility on 3/28/2008. The record did not include complete information as follows: a. There were two nursing progress notes present in a five month period of time from April through September 2008. Other nursing notes were confined to comments on the daily run sheets such as "napping, sitting up and treatment ended". b. There was one social worker progress note during the same time period. c. There were no dietary progress notes documented during the five month period of time from April through September 2008.	V 241	See page 59 of 70	

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V 241	Continued From page 63 7. Patient #7 was a 74 year old male with diagnoses that included ESRD, prostatic cancer and Multiple Myeloma. He was admitted to the facility on 8/20/2008. His medical record from 8/20/08 to 9/22/08 was reviewed. The record did not include complete information as follows: a. No nursing progress notes were present in Patient #7's record. b. Dietician progress notes, recorded in the case conference dated 9/1/08 consisted of, "monitor K+ foods" and "does not gain much/occ loss or same wt." Patient #7's serum phosphorus level was marked as "NA" on the care conference. Information related to what Patient #7 was eating or drinking or dietary suggestions were not included on the notes. c. The record showed initial dialysis MD orders, dated 8/20/08, as well as 6 subsequent MD orders written between 8/20/08 and 9/19/08 that were unsigned. The facility failed to ensure that patients were reassessed in a timely manner.	V 241	See page 59 of 70	
V 423	405.2161(b)(2) RESPONSIBILITIES: TRAINING STAFF The responsibilities of the physician-director include but are not limited to assuring adequate training of nurses and technicians in dialysis techniques. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure technicians were trained in dialysis techniques including water testing. This resulted in the inability of the facility	V 423	All staff responsible for water system monitoring have been further educated and trained regarding proper procedures. An in-service that had been given in the past was revisited with staff members and a handout regarding many aspects of water treatment was also given to staff members. (See attachment 10) A timer has also been placed in the water treatment room to allow for chlorine samples to sit 3- 5 minutes.	11/4/08

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V 423	Continued From page 64 to ensure water was properly tested and safe for use. The findings include: During a tour of the water treatment system on 9/24/08 at 10:30 AM, the technician was asked to demonstrate chlorine testing. The tech sampled the water and then waited 15 seconds prior to reading the results. The package insert for the testing equipment stated the water should be combined with the reagent and should sit for 3-5 minutes prior to testing. The technician was questioned and stated she did not know how long the water needed to sit prior to testing.	V 423	See page 64 of 74	
V 440	405.2163 MINIMAL SERVICE REQUIREMENTS The facility must provide dialysis services as well as adequate laboratory, social, and dietetic services to meet the needs of the ESRD patient. This CONDITION is not met as evidenced by: Based on record review and staff interview it was determined that the facility failed to provide social and dietetic services to meet the needs of ESRD patients. The cumulative effect of these systemic omissions resulted in the inability of the facility to meet patients' social service and dietary needs. The findings include: 1. Refer to V447 as it relates to the facility's failure to ensure the social worker conducted psychosocial evaluations, developed psychosocial POCs, and maintained progress notes. 2. Refer to V449 as it relates to the facility's failure to ensure the dietitian assumed responsibility for assessing nutritional and dietetic needs, recommending therapeutic diets, and counseling patients on prescribed diets.	V 440	Each member of the interdisciplinary team will meet with each patient and perform an initial assessment of the patient's needs and concerns. These assessments will be specific and individualized. (See attachments 6-8) Additionally at least monthly each member of the interdisciplinary team will meet with each patient and discuss their specific needs and concerns. These conversations will be documented in the interdisciplinary progress notes. These items will also be a part of the monthly chart auditing process and will be checked for accuracy against physician's orders monthly	11/5/08

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V 447	405.2163(c) SOCIAL WORKER RESPONSIBILITIES The qualified social worker is responsible for conducting psychosocial evaluations, participating in team review of patient progress and recommending changes in treatment based on the patient's current psychosocial needs, providing casework and groupwork services to patients and their families in dealing with the special problems associated with ESRD, and identifying community social agencies and other resources and assisting patients and families to utilize them. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, it was determined the facility failed to ensure the social worker conducted psychosocial evaluations, developed psychosocial POCs, and maintained progress notes for 8 of 9 patients (#s 2 - 9) whose records were reviewed. These failures impeded the facility's ability to provide needed social services to patients. The findings include: 1. Patient #2 was a 54 year old male with diagnoses of chronic kidney disease, diabetes, and a history of drug abuse. He was admitted to the facility on 6/30/06 and was currently a patient as of 9/23/08. A psychosocial history, dated 7/19/06, stated the patient had undergone 31 abdominal surgeries and had constant pain. The evaluation said the patient had a history of depression. He lived alone. An updated psychosocial evaluation had not been completed since 7/19/06. A "Case Conference" note, written by the physician and dated 7/8/08, stated the social worker was to evaluate the patient for depression. No progress notes by the social	V 447	Social services have been and will continue to be present and actively involved in the patient care planning meetings held monthly. Additionally the social worker will meet with each patient monthly to discuss their specific needs and document any concerns or issues in the interdisciplinary progress notes section of each patient chart. As part of the chart auditing process the facility administrator will also check to ensure that all social services assessments are complete and updated at least annually.	11/3/08

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V 447	Continued From page 66 worker in 2008 were present in the record. The social worker, interviewed on 9/25/08 at 12 noon, stated he had helped Patient #2 as much as anyone. The social worker confirmed the patient was depressed. The social worker said no progress notes had been written in 2008 and no specific social service plan was in place. The social worker said no psychosocial evaluation had been completed since 2006. 2. Patient #3 was a 91 year old male with diagnoses of chronic kidney disease and diabetes. He was admitted to the facility on 7/2/08 for his first dialysis ever and was currently a patient as of 9/23/08. The social worker, interviewed on 9/25/08 at 12 noon, stated Patient #3's psychosocial evaluation had not been completed. 3. Patient #4 was an 89 year old male with diagnoses of glomerulonephritis and cardiac problems. He was admitted to the facility on 12/13/06 and was currently a patient as of 9/23/08. A psychosocial history was dated 1/4/07. No psychosocial problems were documented. The RN, interviewed on 9/25/08 at 2 PM, stated the physician wanted the patient to dialyze for 4 hours but the patient refused and would only dialyze for 3 hours and 15 minutes. The patient's wife, interviewed on 9/24/08 at 8:15 AM., stated the patient often became anxious during dialysis treatments and she had to go sit with him to calm him down. She also stated they needed assistance with money for transportation. No social service progress notes for 208 were present in the record. The social worker, interviewed on 9/25/08 at 12 noon, stated he had helped Patient #4 with money for transportation. The social worker said no progress notes had	V 447	See page 66 of 74	

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V 447	Continued From page 67 been written in 2008 and no specific social service plan was in place. 4. Patient #5 was an 86 year old male with diagnoses of end stage renal disease and long term cardiac disease. He began dialysis at the facility on 6/28/06. His last dialysis treatment occurred on 8/20/08 and he died the following week. A psychosocial history was dated 7/26/06. An updated psychosocial evaluation had not been completed since that date. The patient lived in a nursing home in 2008. Run sheets in 2008 documented the patient was confused at times. A POC, dated 4/7/08, documented the patient needed constant encouragement to come for dialysis treatments. A run sheet, dated 6/2708, stated "PT VERY CONFUSED AND GETTING OUT OF HAND WITH STAFF, SWEARING AND YELLING". A run sheet, dated 7/23/08, stated "DURING THE TX, PT BECAME UPSET/AGGRESSIVE/YELLING AT NURSES TO TAKE HIM OFF TX. MUCH REASSURANCE AND ONE ON ONE REQUIRED TO GET HIM TO 3 HOURS". Two other run sheets in August 2008 documented the patient was agitated and asking to leave treatment early. No progress notes by the social worker in 2008 were present in the record. The social worker, interviewed on 9/25/08 at 12 noon, stated Patient #5 was not compliant with his dialysis treatment "over and over again". He confirmed no progress notes had been written in 2008 and no specific social service plan was in place. 5. Patient #6 was a 61 year old female with diagnoses of renal failure, diabetes and depression. She began dialyzing at the facility on	V 447	See page 66 of 74	

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V 447	Continued From page 68 5/30/06 and was currently a patient as of 9/23/08. Only 2 social service notes were present between 9/23/07 and 9/23/08. The first note, dated 10/29/07, was superficial. It stated the patient had been knitting and crocheting. It said she was more open than in the past and "compliance seems a bit better." Finally, the note said the social worker was waiting on lab "test to see (blood sugar) compliance over time." The next social service note was dated 7/18/08. It stated the patient had talked with a transplant center and needed to lose 40 pounds to be considered for transplant. The patient was going to start on a weight loss program. The note said the patient was receiving financial assistance for transportation. The note did not address compliance or depression. The social worker, interviewed on 9/25/08 at 12 noon, stated he had worked on several issues with Patient #6. He confirmed no social service notes were present in the record for 2008 except for the 7/18/08 note. He stated no specific social service plan had been developed for this patient. 6. Patient #7 was a 74 year old male with diagnoses that included ESRD, prostatic cancer and Multiple Myeloma. He was admitted to the facility on 8/20/2008. There had been no contact with Social Services as of the date of survey on 9/22/08. The patient had been receiving dialysis services for over thirty days at that time, and had experienced more than one life changing event just prior to his admission, creating additional psychosocial needs to be addressed. There was no specific psychosocial care plan in place for this patient. 7. Patient #8 was an 89 year old female with diagnoses of renal failure and diabetes. She was	V 447	See page 66 of 74	

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V 447	Continued From page 69 admitted to the facility on 6/5/2006. She had a Social Services assessment on 8/25/06. At that time the patient was living with her son and was ambulatory. Since that time, the patient had transferred to a SNF and was wheelchair bound, requiring mechanical assistance for transfers. There had been no contact documented by the Social Worker since 8/2006 to address additional needs associated with the patient's loss of independence and mobility. 8. Patient #9 was a 60 year old female with diagnoses of renal failure, diabetes and stroke. She was admitted to the facility on 4/4/2008. A psychosocial assessment was done at the time of admission when the patient was an inpatient at the hospital. No contact or follow up by the Social Worker was documented when the patient was discharged home, where she lived alone, to address additional patient needs associated with this change. Further, a Social Worker note was included in the Case Conference, dated 8/15/08. It said "relatives stated worried about depression". The Social Worker wrote that he had notified the doctor. His plan of action consisted of "wait and see if M.D. prescribes". No further notes were documented about the outcome for the patient or other intervention by the Social Worker on the patient's behalf. The facility failed to ensure the social worker conducted psychosocial evaluations, assessed patient's needs or provided casework services to the facility's dialysis patients.	V 447	See page 66 of 74	
V 449	405.2163(d) DIETITIAN RESPONSIBILITIES The dietitian, in consultation with the attending physician, is responsible for assessing the nutritional and dietetic needs for each patient,	V 449	See page 71 of 74	

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V 449	Continued From page 70 recommending therapeutic diets, counseling patients and their families on prescribed diets, and monitoring adherence and response to diets. This STANDARD is not met as evidenced by: Based on review of clinical records and staff interview, it was determined the facility failed to ensure the dietitian assumed responsibility for assessing nutritional and dietetic needs, recommending therapeutic diets, and counseling patients on prescribed diets. The dietician failed to provide services to 8 of 9 patients (#s 2 - 9) whose records were reviewed. These failures impeded the facility's ability to ensure patients received appropriate diets. The findings include: 1. Theh medical records of Patients #2 - 9 were reviewed. The records did not included documentation of comprehensive dietetic assessments, planning, education and monitoring as follows: a. Patient #2 was a 54 year old male with diagnoses of chronic kidney disease and diabetes. He was admitted to the facility on 6/30/06 and was currently a patient as of 9/23/08. No dietary progress notes for 2008 were present in the record. No documentation of assessing Patient #2's nutritional and dietetic needs, recommending a therapeutic diet, or dietary counseling was present in his record in 2008. b. Patient #3 was a 91 year old male with diagnoses of chronic kidney disease and diabetes. He was admitted to the facility on 7/2/08 for his first dialysis ever and was currently a patient as of 9/23/08. A dietary evaluation was not present in his record. The dietician, interviewed on 9/24/08, at 4:10 PM, stated a	V 449	Dietary services have been and will continue to be present and actively involved in the patient care planning meetings held monthly. Additionally the dietician will meet with each patient monthly to discuss their specific needs and document any concerns or issues in the interdisciplinary progress notes section of each patient chart. As part of the chart auditing process the facility administrator will also check to ensure that all dietary assessments are complete and updated at least annually. Any education given to or provided for the patient will also be documented in the newly added patient education record form. (See attachment 9)	11/3/08

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V 449	Continued From page 71 dietary evaluation had not been completed. c. Patient #4 was an 89 year old male with diagnoses of glomerulonephritis and cardiac problems. He was admitted to the facility on 12/13/06 and was currently a patient as of 9/23/08. No dietary progress notes for 2008 were present in the record. No documentation of assessing Patient #4's nutritional and dietetic needs, recommending a therapeutic diet, or dietary counseling was present in his record in 2008. d. Patient #5 was an 86 year old male with diagnoses of end stage renal disease and long term cardiac disease. He began dialysis at the facility on 6/28/06. His last dialysis treatment occurred on 8/20/08 and he died the following week. No dietary progress notes for 2008 were present in the record. No documentation of assessing Patient #5's nutritional and dietetic needs, recommending a therapeutic diet, or dietary counseling was present in his record in 2008. The dietician, interviewed on 9/24/08, at 4:10 PM, stated the patient resided in a nursing home and had dietary notes in the nursing home but did not have documentation in the facility notes. e. Patient #6 was a 61 year old female with diagnoses of renal failure, diabetes and depression. She began dialyzing at the facility on 5/30/06 and was currently a patient as of 9/23/08. No progress notes by the dietician were present in the record for 2008. A social service note, dated 7/18/08, stated the patient had talked with a transplant center and needed to lose 40 pounds to be considered for transplant. The note said the patient was going to start on a weight loss	V 449	See page 71 of 74	

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V 449	Continued From page 72 program. This was not documented by the dietician and no plan was documented for the patient to lose weight. f. Patient #8 was an 89 year old female with diagnoses of renal failure and diabetes. She was admitted to the facility on 6/5/2006. No documentation of assessing this patient's nutritional and dietetic needs, recommending a therapeutic diet, or dietary counseling was present in her record in 2008. No dietary progress notes for 2008 were present in the record. The dietician, interviewed on 9/24/08, at 4:10 PM, stated the patient resided in a nursing home and had dietary notes in the nursing home but did not have documentation in the facility notes. g. Patient #9 was a 60 year old female with diagnoses of renal failure, diabetes and stroke. She was admitted to the facility on 3/28/2008. Her initial dietary assessment was done while she was a patient in the hospital. The patient was malnourished at the time of her admission as documented by laboratory values that showed an Albumin level of 2.4. Acceptable Albumin level was 3.5 or higher. No dietary progress notes were present in the record after the initial assessment. She was later discharged home, where she lived alone. No documentation was present in her record showing dietary reassessment for potential problems that may have been present as a result of the change, such as the patient's ability to obtain groceries and prepare adequate meals. h. Patient #7 was a 74 year old male with diagnoses of renal failure and multiple myeloma.. He had been undergoing dialysis treatments at	V 449	See page 71 of 74	

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V 449	Continued From page 73 the facility since August, 2008. There was no documentation that a thorough dietary assessment had been done for Patient #7. During interview on 9/22/08 at 3:00 PM, the patient's wife indicated that she prepared the patient's meals. She had numerous misconceptions about his dietary restrictions. It was her understanding that the patient could only eat foods prepared at home from "scratch". She further stated that she had not consulted with the dietician. Dietician progress notes, recorded in the case conference dated 9/1/08 consisted of, "monitor K+ foods" and "does not gain much/occ [occasional] loss or same wt." Patient #7's serum phosphorus level was marked as "NA" on the care conference. Information related to what Patient #7 was eating or drinking or dietary suggestions were not included on the notes. The dietician was interviewed on 9/24/08, at 4:10 PM. She stated she spoke with patients regarding their diets and laboratory results at least once per month but did not document this well. She said she was not always consistent documenting what dietary handouts she gave to patients. When asked, she stated there were no current patients with documented specific dietary goals. The facility failed to ensure the dietician assessed each patient's needs, recommended diets, counseled patients or monitored adherence and response to diets.	V 449	See page 71 of 74	